

# ATTACHMENT 3

## Sample CMS 1500 claim form for oral surgery services

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <div style="text-align: center; font-weight: bold;">1234567890</div>				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <div style="font-weight: bold;">Recipient, Im A.</div>					3. PATIENT'S BIRTH DATE <div style="font-weight: bold;">MM DD YY</div>				
5. PATIENT'S ADDRESS (No., Street) <div style="font-weight: bold;">609 Willow St</div>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				
7. INSURED'S ADDRESS (No., Street) 					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <div style="font-weight: bold;">OI-P</div>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO				
11. INSURED'S POLICY GROUP OR FECA NUMBER <div style="font-weight: bold;">M-8</div>					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. RESERVED FOR LOCAL USE				
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <u>750.0</u>				
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER <div style="font-weight: bold;">1234567</div>				
24. A DATE(S) OF SERVICE From To MM DD YY MM DD YY					B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER				
E DIAGNOSIS CODE <div style="font-weight: bold;">1</div>					F \$ CHARGES <div style="font-weight: bold;">XXX XX</div>				
G DAYS OR UNITS <div style="font-weight: bold;">1.0</div>					H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE <div style="font-weight: bold;">12345678</div>				
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. <div style="font-weight: bold;">1234JED</div>				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE <div style="font-weight: bold;">\$ XXX XX</div>				
29. AMOUNT PAID <div style="font-weight: bold;">\$ XX XX</div>					30. BALANCE DUE <div style="font-weight: bold;">\$ XX XX</div>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <div style="font-weight: bold;">J.M. Williams</div>					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <div style="font-weight: bold;">I.M. Provider 1 W. Williams Anytown, WI 55555 87654321</div>					PIN# _____ GRP# _____				

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)